DOLPHIN MEDICAL GROUP OFFICE POLICIES

Thank you for choosing Dolphin Medical Group for your primary care needs. We are committed to providing the finest personalized and professional care possible to you, our patient. We hope that the following information will help answer some of your questions and help you understand how our office operates.

Appointments

We value our time with you and want to be sure that we are able evaluate and discuss the main reason that you made the appointment, whether that is treatment for a new problem, an ongoing problem or a well visit.

The amount of time scheduled for each of these situations is different. Therefore, we would appreciate that when you make your appointment, you tell us which of these types of problems best fit the reason for your visit. This will insure that not only your problem will be given the full time and attention that it requires but other patients will not be kept waiting. We realize all our patients are busy and their time, as well as the doctors, is valuable so to best serve you please try to limit the discussion to the reason for your visit.

Office Visit Guidelines

Our clinical practice guidelines, state board of medicine, malpractice insurance carrier, and/or your health insurance plan require a physician to see you in the office under each of the following circumstances:

- Any new symptom or new medical condition not previously treated at Dolphin Medical Group.
- Any new occurrence/recurrence of a condition that has been previously treated at Dolphin Medical Group.
- Any request for medication not previously prescribed by a physician at Dolphin Medical Group.
- Any request for a diagnostic test/blood test not previously discussed with the provider.
- Refills on controlled substances.

Canceled/Missed Appointments

We realize that patients may need to change their appointments; however, we require a 24 hour notification of cancellation for appointments so that we may offer that time to another patient. If you fail to cancel and appointment, or no show for your scheduled appointment, you will be charged a $25 fee. This amount can not be billed to your insurance. If you miss two appointments without calling, we may choose to discharge you from the practice. If you are 15 minutes or more, late for an appointment, we may ask you to reschedule.

Referrals/Authorizations

When your provider suggests a specialist evaluation or diagnostic testing that requires a referral, we will make every effort to provide this for you as soon as possible. Some referrals require insurance preauthorization and cannot be processed immediately. We require 3-5 business days for processing of routine referrals.

Medical Forms

Our physicians receive frequent requests to write, complete, and/or send various letters, forms, and other paperwork for our patients. The fee for these forms will be $25 for up to 3 pages and $5 per page thereafter. Forms cannot be completed while you wait, and you may need an office visit in order for the provider to complete the requested forms.

Co-pays

Co-pays are due at the time of service. The agreement of the insurance carrier to pay for your medical care is a contract between you and your insurance company. Any amount not covered by your insurance company is your financial responsibility. This includes co-payment, co-insurance and deductibles. If you have an outstanding balance on your account that is over 60 days, you will be required to make arrangements for payment prior to scheduling an appointment.

Phone Calls

Every effort is made to return phone calls on the same day, but due to high volume of calls received, this is not always possible. We will return your call as soon as possible.

Patient Name: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of, or the option of reading the Notice of Privacy Practices of Dolphin Medical Group. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 941-776-1400.

If you have any questions about our Notice of Privacy Practices, please contact the Practice Manager at the telephone number listed above.

I acknowledge receipt of, or the option of reading the Notice of Privacy Practices of Dolphin Medical Group.

_____ _____

Signature (patient, parent, guardian) Date

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained:

_____
_____
_____
_____

_____ _____

Signature of provider representative Date

INFORMATION DISCLOSURE

According to HIPPA regulations, we must obtain permission to leave medical information on voicemails, answering machines, or with any persons other than you.

Please fill out and sign below:

I give permission to the staff of Dolphin Medical Group to leave messages in the following manor:

- Leave message on my home phone answering machine or voicemail
- Leave message on my work voicemail
- Leave a message on my cell phone voicemail
- Leave a message with the following people: (Name/Relation/Phone)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

*Keep in mind that, by law, if a spouse, relative etc. is not listed above, we **MAY NOT** discuss your medical care with them.

Signature _____ Date _____

Name of signee _____

Name: _____ Date: _____

New Patient Information Form

Allergies: _____

MEDICAL PROBLEMS (i.e. high blood pressure, cholesterol, diabetes, asthma, mental illness, etc):

_____

_____

_____

SURGICAL HISTORY (please list **ALL** surgeries you have had and **YEAR**):

_____

_____

MEDICATIONS (can skip if brought list or bottles):

Drug	Mg/Strength	How Often	Drug	Mg/Strength	How Often

REASON(s) FOR YOUR VISIT TODAY:

	Reason 1	Reason 2
Explanation		
Frequency of Symptoms		

What makes it better?		
What makes it worse?		
Previous treatment/meds		

REVIEW OF SYSTEMS

Yes or No		**Yes or No**		**Yes or No**	
	Recent fever		Asthma or bronchitis		History of STDs
	Weight loss		Shortness of breath		Painful urination
	Changes in vision (glaucoma,cataracts)		Frequent indigestion or heartburn		Frequent bone fracture or muscle sprains
	Hearing loss		Nausea/Vomiting		Changes in skin/mole
	Nasal congestion		Diarrhea		Seizures
	Sinusitis		Constipation		Psychiatric illness
	Sore throat		Bloody or Black Stools		Easy bleeding or bruising
	Chest pains		Blood in urine		Severe allergic reactions

FEMALES ONLY:

Last period: _____ Hysterectomy: Yes or No For What reaons: _____

Number of pregnancies: _____ Number of children: _____ Last mammogram: _____ Normal or abnormal

Last PAP: _____Normal or abnormal History of abnormal PAP: Yes or No

IMMUNIZATIONS (list year received)

Influenza (flu): _____ Pneumonia: _____ Tetanus: _____ Shingles: _____

SOCIAL HISTORY:

Smoke: Yes or No Packs/day: _____ Previous smoker: Yes or No Packs/day: _____

Caffeine Use: Yes or No Amount: _____ Alcohol use: Yes or No Amount:_____

Current employment: _____

FAMILY HISTORY (place checkmark if family member has condition):

	Mom	**Dad**	**Sister (s)**	**Brother (s)**	**Grandparents (s)**
Alive or Dead					
High blood pressure					
High cholesterol					
Diabetes					
Stroke					
Heart Attack					
Cancer (list type)					
Other illness					

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Louis Casado, MD
Stella Chang, PA-C
Nora Abadir, PA-C

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, request and authorize release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable disease) to the physician listed above.

This release is authorized for one year from the date of signing and all information will be regarded as confidential. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.

Please forward the following:
_____

O Complete medical, surgical and medication history

O Office notes and examination findings

O Correspondence and consultation letters

O EKG images and reports.

O Radiology reports.

O Laboratory reports.

RELEASE MY MEDICAL RECORDS FROM:

Name: _____

Phone: _____ Fax: _____

_____ _____

Print Name Patient's Date of Birth

_____ _____

Patient's Signature Today's Date

New Patient Questionnaire

Name:_____ DOB___/___/___ Social Security #_____
Home Phone:_____ Work Phone:_____ Cell:_____
Gender:____ Race_____ Ethnicity_____Language_____ Religion_____
Marital Status: S M W D **Preferred Pharmacy:_____ Pharm Location_____**
Primary Address:_____
Secondary Address:_____
Email Address:_____
Employment Status : __ Full Time __ Part Time __ Unemployed___ Student
Occupation_____
Reason for visit:_____
How did you hear about us?_____
Primary Insurance Carrier:_____
Name/realtion of Insured:_____
Policy #_____ Group #_____

Secondary Insurance Carrier:_____
Name/relation of Insured:_____
Policy #_____ Group #_____

Emergency Contact: (Name/relation/phone)_____
MINOR: Parent/Guardian names/numbers _____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring physicians and to my insurance company. I allow fax transmittal of my medical records. I acknowledge full responsibility for services rendered by Dolphin Medical Group. I understand payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Amanda Lindberg, MD, Lura Springfels, ARNP/Dolphin Medical Group should they elect to receive such payment. I have fully read and understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature:_____ Date:_____

Name/Relation of signee _____ _____

Dolphin Medical Group

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of our treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will be happy to file your insurance claims for you. However, we do require co-pays and deductibles to be paid at the time of service. We cannot bill your insurance company unless you provide us with correct insurance information, both primary and secondary and requested forms of other identification, such as a driver's license. Your insurance policy is a contract between you and your insurance company. We will accept the contracted allowable fees if we participate with your specific insurance plan.

MEDICARE PATIENTS

We are participating providers and accept assignment for Medicare benefits. We are also a provider for many of the Medicare replacement plans. However, you are ultimately responsible for any deductibles and the difference between the amount approved and the amount paid by Medicare and your secondary insurance when applicable. Please be aware that certain services provided may be non-covered services and/or not considered reasonable and necessary under the Medicare program. Under these conditions you will be required to sign an Advanced Beneficiary Notice (ABN) for these specific services.

USUAL AND CUSTOMARY

We are committed to providing the best treatment for our patients and our services reflect usual and customary fees for our area. You will be notified prior to any procedure or service which may not be covered by your insurance so payment can be made.

RETURNED CHECKS

We charge a $35.00 fee on all returned checks.

Please note if your account is sent to an outside agency/attorney for collection of an unpaid balance a fee of 35% will be assessed on top of your outstanding balance.

I have read and understand the above and agree to comply with this Financial Policy.

_____ _____

Signature of patient or responsible party Date

PATIENT AGREEMENT : WELL VISIT vs. PROBLEM VISIT

In compliance with insurance regulations, our office policy does not allow for both a well visit and a problem visit at the same time.

I understand that my indicated appointment today was for:

1. __ My annual Well Visit. Your Wellness Visit will include, among other things, a medical history, health risk assessment and an evaluation of physical condition and screening for cognitive impairment. In addition, your doctor will work with you to set a prevention plan, including appropriate health screenings. ***I understand that I will need to schedule a problem visit for <u>any problems</u> I am experiencing at a later date.*** My medications may not be refilled at this visit.

2. __ My problem visit. ***If you are being seen as a <u>new patient</u> and have chronic medical problems or are on medications you would need to select this option and schedule a well visit at a later date.***

Dolphin Medical Group would like to stress the importance of the annual Well Exam. If you have chosen to see the provider for your problem visit today, our staff will assist you in making the appointment for your Well Exam for a later date before you leave the office today. The annual Wellness Visit is a strategy session designed to help you and your doctor develop an ongoing health plan indeed to keep you healthy, safe and independent for years to come.

_____ _____

Patient Signature Date

_____ _____

Patient Name Witness

Dolphin Medical Group Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. Appointment time is reserved for you alone. When you make an appointment, please be sure that you will be able to keep it.

Like many offices, this office does call to confirm your appointment. Please make a note of any appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. There may be a charge of $25 for a no-show or cancellation with less than 24 hours' notice for your appointment.

Patient Name:_____ Date:_____

Patient Signature:_____